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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31647

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 770

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

926

1. PLACE OF DEATH:
(a) County ~~Missouri~~ Greene
(b) City or town Greene Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week 0 (Specify whether
In this community 35 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 034
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 5
(d) Street No. 605 S. Florence
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lelia Page Holland
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles Holland
6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased Feb. (Month) 26 (Day) 1893 (Year)

8. AGE: Years	Months	Days	If less than one day
50	6	20	hr. min.

9. Birthplace Unk. (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name F.C. Page
13. Birthplace Unk. (City, town, or county) Pennsylvania (State or foreign country)

MOTHER
14. Maiden name Ida Unk.
15. Birthplace Unk. (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Charles Holland
(b) Address Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 9-20-43 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16
year 1943 hour 5 minute 20 P.M.
21. I hereby certify that I attended the deceased from March 2 1943 to Sept. 16 1943
that I last saw h.er alive on Sept 16, 1943 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Aplastic Anemia	7 Mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 1382	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. E. Allen (M. D. or other)
Address Springfield, Mo. Date signed 9-20-43

-186

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Addr Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

OCT

State File No. .....

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 770

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Missouri, Springfield.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Lelia Page Holland

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... Years

7. Birth date of deceased Feb (Month) 26 (Day) 89 (Year)

8. AGE: Years 50 | Months 6 | Days | If less than one day: ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Iowa (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) E. W. Hardesty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day ..... year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h.. alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY 46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

31647